

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, F11-6230 6-23-58 et

CERTIFICATE OF DEATH

6682

Reg. Dist. No.

06673

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>1 Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester MD</u>		c. LENGTH OF STAY IN 1b <u>5MO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore MD</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>				d. STREET ADDRESS <u>2969 Keowick Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARVEY S. ARMACOST</u>				4. DATE OF DEATH Month Day Year <u>June 16 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1867</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stapple Annacost</u>				14. MOTHER'S MARDEN NAME <u>Martha Ellen Armacost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Robert Kemp - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardiovascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUN 29</u> , 19 <u>58</u> to <u>June 16</u> , 19 <u>58</u> that I last saw the deceased alive on <u>June 15</u> , 19 <u>58</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>		DATE SIGNED <u>9/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>				HAMPSTEAD MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-18-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Graves Run</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

12827

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		M		45		10-15-1880		BALTIMORE, MD.		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PRESENTING COMPLAINT		16. MEDICAL HISTORY	
10-20-1925		10:00 AM		HOME		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		PAIN IN CHEST		HYPERTENSION	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF CLERK		23. SIGNATURE OF CHURCH		24. SIGNATURE OF OTHER	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

Printed in front of Bureau of Health, State Department of Health, Baltimore, Md. This form is to be filled out by the physician or other person in charge of the death record. It is to be filed in the Bureau of Health, State Department of Health, Baltimore, Md. It is to be filled out by the physician or other person in charge of the death record. It is to be filed in the Bureau of Health, State Department of Health, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6683

CERTIFICATE OF DEATH

06674

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>4 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Andrews Nursing Home</u>				e. STREET ADDRESS <u>Edmondson Ave. Laurel Hill</u>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH MARIE BECK</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>26</u> Year <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 27. 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>	
13. FATHER'S NAME <u>Conrad Hausmann</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George W Beck - Elchester Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> XXX <u>HYPERTENSIVE CARDIOVASCULAR DISEASE with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS and MYOCARDITIS</u> DUE TO (c) <u>SENILE CHANGES</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>23 February '58</u> to <u>26 June '58</u> , that I last saw the deceased alive on <u>26 June '58</u> , and that death occurred at <u>10550AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Lawson Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>6.26. 1958</u>			
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr. M.D.</u>				Sykesville P.O., Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 30 / 58</u>		<u>Landon Park</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Deifel</u> ADDRESS <u>5311 Edmondson Ave</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Schuch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06675

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mos., 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hospital				d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruthanna Middle Margaret Last Bemiller				4. DATE OF DEATH Month June Day 12 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 12		IF UNDER 24 HRS. Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Bemiller				14. MOTHER'S MAIDEN NAME Eliza Willet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) Infected pressure sores upper right arm & chest (a), stating the underlying cause last. DUE TO (c) Dislocation & fracture, right humerus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction. 491X							INTERVAL BETWEEN ONSET AND DEATH 3 days Weeks 4 months
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown					
20c. TIME OF INJURY Month, Day, Year Unknown 2/4 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James T. Marsh</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
22d. LOCATION (City, town, or county) (State) Silver Run. Carroll Co. Md.		22e. REC'D BY REGISTRAR Richard A. Little		22f. REGISTRAR'S SIGNATURE <i>Richard A. Little</i>		DATE JUN 13 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6685

Item 14 Film 231 7-7-58 et

CERTIFICATE OF DEATH

06676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marblehead</u>			c. LENGTH OF STAY IN 1b <u>2MO</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Harrover</u> 75 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>121 York St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERMA</u> Middle <u>Bixler</u> Last <u>Bixler</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joel Henry</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Robert C Bixler, Harrover P.A.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>58</u> , to <u>June 30</u> , 19 <u>58</u> that I last saw the deceased alive on <u>June 30</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>6/30/58</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Harrover Pa York Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucker</u> ADDRESS <u>Harrover Pa</u>				24a. REC'D BY REGISTRAR <u>Jul 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6686

CERTIFICATE OF DEATH

Reg. Dist. No. 74

06677

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 42 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Brunner Last Brunner		4. DATE OF DEATH Month June Day 2 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1913
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jim Brunner		14. MOTHER'S MAIDEN NAME Celia Nickens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT James Brunner - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx and Larynx 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Far advanced pulmonary tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 002X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1958 , to June 2, 1958 , that I last saw the deceased alive on June 2, 1958 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-2-58 ACTUAL SIGNATURE Edgars M. Maculans M.D. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D., Supt. Henryton State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-58	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Snowden		24a. REC'D BY REGISTRAR Abraham	
ADDRESS Rockville		24b. REGISTRAR'S SIGNATURE Abraham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. HENRY		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
100 N. ST. BOSTON		JAN 15 1922		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
CLOCK REPAIRER		8 YEARS		MARRIED		NONE		NONE	
BIRTH		DEATH		BURIAL		INTERMENT		OTHER	
JAN 1 1877		JAN 15 1922		CATHOLIC		ST. MARY'S		NONE	
FATHER		MOTHER		SISTER		BROTHER		OTHER	
JAMES J. HENRY		MARY J. HENRY		JOHN J. HENRY		MICHAEL J. HENRY		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
J. J. HENRY		J. J. HENRY		J. J. HENRY		J. J. HENRY		J. J. HENRY	
DATE		TIME		PLACE		CAUSE		MANNER	
JAN 15 1922		10:00 AM		HOME		HEART DISEASE		NATURAL	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6687
CERTIFICATE OF DEATH

Reg. Dist. No. 06678

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>	c. LENGTH OF STAY IN 1b <u>YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHURCH ST</u>		d. STREET ADDRESS <u>CHURCH ST</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>BELLE</u> Last <u>BUCKINGHAM</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 3 - 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LEVI WINTERS</u>	
14. MOTHER'S MAIDEN NAME <u>MARY ANN ELLETT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WM S BUCKINGHAM</u> Address <u>MD</u> <u>NEW WINDSOR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 30, 1956</u> , to <u>6/26/58</u> , that I last saw the deceased alive on <u>6/25/58</u> , 12 _____, and that death occurred at <u>12:40 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.E. Robertson</u>		ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>6/26/58</u>	
PHYSICIAN'S NAME (Type) <u>ME ROBERTSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>
22d. LOCATION (City, town, or county) (State) <u>CARROLL CO</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler & Sons</u>		ADDRESS <u>New Windsor Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Leach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. BROWN</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>LABORER</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. DATE OF MARRIAGE <u>1935</u>	
9. PLACE OF DEATH <u>HOME</u>		10. CAUSE OF DEATH <u>HEART DISEASE</u>	
11. DATE OF DEATH <u>1955</u>		12. TIME OF DEATH <u>10:00 AM</u>	
13. SIGNATURE OF DECEASED <u>[Signature]</u>		14. SIGNATURE OF WITNESS <u>[Signature]</u>	
15. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		16. SIGNATURE OF CORONER <u>[Signature]</u>	
17. SIGNATURE OF REGISTRAR <u>[Signature]</u>		18. SIGNATURE OF CLERK <u>[Signature]</u>	



CERTIFICATE OF DEATH

06679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grand View Nursing Home</u>		d. STREET ADDRESS <u>Formerly of 2053 Kennedy Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>VIOLA</u> Last <u>CADWALLADER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel King</u>		14. MOTHER'S MAIDEN NAME <u>Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Edgar C. Cadwallader-4018 Loch Raven Blvd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Bladder</u> <u>181.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mos</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> to <u>20 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19 June</u> , 19 <u>58</u> , and that death occurred at <u>12:03 A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>6.20.58</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Liberty Road at Eldersburg</u>			
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER & SONS - Balto. 17, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06680
Items 2, 8 & 9, Film G231, 7/11/58 fcy										
6689										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 10 mos. 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 12 E. Mt. Royal Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					3V01.4
3. NAME OF DECEASED (Type or print) First Bessie Middle Cannon Last Cannon					4. DATE OF DEATH Month June Day 28 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/2/13 4/10/69		9. AGE (In years last birthday) 88 9 yrs.		IF UNDER 1 YEAR Months 8 Days 28 Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Kind Cannon					14. MOTHER'S MAIDEN NAME Charlotte Elizabeth Penz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital, Sykesville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the head of the pancreas DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH Weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10/20 , 19 54 , to 6/28 , 19 58 , that I last saw the deceased alive on 6/28 , 19 58 , and that death occurred at 12:00 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED June 30, 1958 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/4/58		22c. NAME OF CEMETERY OR CREMATORY H. G. Md. Anatomical Board 29 S. Greene St.		22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06681

6690

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5 mos. 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2836 Cup Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle Venton Last CLAYTON				4. DATE OF DEATH Month June Day 13 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone cutter				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown JAMES Peter CLAYTON				14. MOTHER'S MAIDEN NAME Unknown MARGARET DEAUER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 213-10-3419		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe interstitial pulmonary fibrosis DUE TO (c) Pneumoconiosis.							INTERVAL BETWEEN ONSET AND DEATH Days Years Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. 491X							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20f. (County)		20f. (State)	
21. I certify that I attended the deceased from Dec. 20, 1958 , to June 13, 1958 , that I lost the deceased on June 12, 1958 , and that death occurred at 4:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 6/13/58							
ACTUAL SIGNATURE Agustin del Campo				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-16-58				22b. DATE THEREOF 6-16-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore	
22d. LOCATION (City, town, or county) Balto				22d. LOCATION (City, town, or county) Balto		22d. LOCATION (City, town, or county) Balto	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Luck				23. FUNERAL DIRECTOR'S SIGNATURE 3305 Naylor St		24a. REC'D BY REGISTRAR DATE JUN 17 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith				24b. REGISTRAR'S SIGNATURE Alfred Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6691

CERTIFICATE OF DEATH

Reg. Dist. No.

06682

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102.2 ✓ d. STREET ADDRESS 503 N. Mechanic St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Bessie Middle Conner Last Conner		4. DATE OF DEATH		Month June Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 448x DUE TO (c) Chronic brain syndrome due to senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to senility							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/9 , 19 58 , to 6/26 , 19 58 , that I last saw the deceased alive on 6/26 , 19 58 , and that death occurred at 1:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo		M.D. Agustin del Campo, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 6/26/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6.27.58		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Scholastic		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE 6/27/58		24b. REGISTRAR'S SIGNATURE W. H. Scholastic	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06683

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>28yrs. 6mos. 20days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>5508 Craig Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Croslin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Solicitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 9027 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intertrochanteric fracture left femur</u> DUE TO (c) <u>Schizophrenic, paranoid type.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>4 weeks plus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic, paranoid type.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell when getting up from chair.</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:10</u> <u>5/24/</u> <u>58</u> Hour <u>500</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Sykesville</u>	(County) <u>Carroll</u>	(State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6/24/58</u>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>UN 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. T. Search</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6693

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN IB 6 m 30 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2, Md.		3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 411 E. Preston Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jerome Middle Garfield Last Danecker		4. DATE OF DEATH Month 6 Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 7/23/1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising business		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland - Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. William Danecker		14. MOTHER'S MAIDEN NAME Carrie Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. XXXXXX None	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unlisted tumor of Kidney DUE TO (c) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction		INTERVAL BETWEEN ONSET AND DEATH months months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-22- 57 , to 6-20 , 19 58 , that I last saw the deceased alive on 6-20- 19 58 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6-21-58	
ACTUAL SIGNATURE Edmund Lusthaus M.D.		PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Son		24a. REC'D BY REGISTRAR JUN 24 58	
ADDRESS Balt - 12, Md.		24b. REGISTRAR'S SIGNATURE W. J. Tucker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Natural		Heart Disease		Jan 15, 1965		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Illness		Time of Death		Time of Burial		Burial Place		Burial Date		Burial Place		Burial Date		Burial Place	
Teacher		Married		Hypertension		Chest Pain		10:00 AM		10:30 AM		St. Mary's Church		Jan 16, 1965		St. Mary's Church		Jan 16, 1965		St. Mary's Church	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	

RECEIVED FROM

FILED IN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6694

CERTIFICATE OF DEATH

Reg. Dist. No.

06685

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. STREET ADDRESS 2621 Maryland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Harrison Last DARNELL				4. DATE OF DEATH Month June Day 17, Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown - Carpenter				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Glick Darnell				14. MOTHER'S MAIDEN NAME Louisa Bare Darnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X not DUE TO Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized arteriosclerosis. (c) Generalized arteriosclerosis.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 26, 19 58 , to June 17, 19 58 , that I last saw the deceased alive on June 17, 19 58 , and that death occurred at 1:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/17/58			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				SYKESVILLE, MARYLAND			
22a. MANNER OF REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
EMERALD		6/20/58		VIEW Cem		MARYLAND N.Y.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Nigro				ADDRESS Ed. Nigro, E. Christ City, Md.		24a. REC'D BY REGISTRAR JUL 1 '58	
						24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6695

CERTIFICATE OF DEATH

Reg. Dist. No. 06686

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BARK HILL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EDWARD DAYHOFF</u>				4. DATE OF DEATH Month Day Year <u>JUNE 21 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 25-1885</u>		9. AGE (In years last birthday) yrs. <u>73</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN T DAYHOFF</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE DAUGHERTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>23-03-1010</u>		17. INFORMANT <u>SUSAN L DAYHOFF</u>		Address <u>RURAL UNION BRIDGE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac dilatation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 2, 1958</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 20, 1958</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. N. Legg</u>				ADDRESS (Street, city or town, state) <u>Union Bridge Md</u>			
M.D. <u>T. H. Legg M.D.</u>				DATE SIGNED <u>June 24 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons</u>				ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6696

CERTIFICATE OF DEATH

06687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 2 y. 3 m. 14 d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amanda Middle Viola Last Elswick				4. DATE OF DEATH Month June Day 8 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bryson Atkins				14. MOTHER'S MAIDEN NAME Sara ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X		20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 1, 1957 , to June 8, 1958 , that I last saw the deceased alive on June 8, 1958 , and that death occurred at 6:50 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rita S. Glahn				ADDRESS (Street, city or town, state) Springfield State Hosp. DATE SIGNED 6/8/58			
PHYSICIAN'S NAME (Type) RITA S. GLAHN				M.D. SPRINGFIELD STATE HOSP. Md.			
22a. BURIAL, CREMATION, REMOVAL REMOVAL		22b. DATE THEREOF 6-9-58		22c. NAME OF CEMETERY OR CREMATORY Laurel Cemetery		22d. LOCATION (City, town, or county) (State) Boone Co., West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR JUN 10 1958	
				24b. REGISTRAR'S SIGNATURE Alb. Lewis			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/interment permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6697

06688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 3mos.17days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 217 Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Minnie Viola Middle Dorsey Last FRESHOUR			4. DATE OF DEATH Month June Day 13 , Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 6 Days 13 Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John B. Dorsey		
14. MOTHER'S MAIDEN NAME Helen Snyder			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. -			17. INFORMANT Address Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture, right femur (a), stating the underlying cause last. DUE TO (c) 9027					INTERVAL BETWEEN ONSET AND DEATH Days 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. 491X					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped & fell while attempting to get off commode.			
20c. TIME OF INJURY Month, Day, Year 11:25 a.m. May 2, 1958	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Sykesville	(County) Carroll	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James T. Marsh</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/13/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/15/58	22c. NAME OF CEMETERY OR CREMATORY BETHEL CH. CEM.	22d. LOCATION (City, town, or county) BERKELEY SPRINGS	(State) W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luther H. Haight</i>		ADDRESS Sykesville, MD.		24a. REC'D BY REGISTRAR DATE JUN 17 '58	24b. REGISTRAR'S SIGNATURE <i>W. H. Haight</i>

15

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2

06

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT.

NAME OF DECEASED BERTHA G. GUN	
SEX F	
AGE 61	
DATE OF DEATH 11/13/33	
PLACE OF DEATH 1111 N. W. 10th St. N.W.	
CITY WASHINGTON, D.C.	
COUNTY DISTRICT OF COLUMBIA	
STATE DISTRICT OF COLUMBIA	
OCCUPATION None	
CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER J. Edgar Hoover	
TITLE OF EXAMINER Medical Examiner	
SIGNATURE OF ATTENDING PHYSICIAN J. Edgar Hoover	
TITLE OF PHYSICIAN Physician	
SIGNATURE OF CORONER J. Edgar Hoover	
TITLE OF CORONER Coroner	

11/13/33 BERTHA G. GUN
 1111 N. W. 10th St. N.W.
 WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6698

CERTIFICATE OF DEATH

Reg. Dist. No.

06689

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6mos. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. STREET ADDRESS 312 N. Paca St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry S. Middle SMITH Last FULTON		4. DATE OF DEATH Month June Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1869
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Fulton		14. MOTHER'S MAIDEN NAME Gatherine Oster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-22-2843	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) 420.0 DUE TO (c) C.B.S. assoc. with senile brain disease with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 19, 19 57 , to June 6, 19 58 , that I last saw the deceased alive on June 5, 19 58 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 6/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker		24a. REC'D BY REGISTRAR JUN 9 '58	
ADDRESS Balto - Md.		24b. REGISTRAR'S SIGNATURE W. J. Tucker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First William Middle I. Last Gates		4. DATE OF DEATH Month June Day 10 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Generalized arteriosclerosis (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S.assoc.with cerebral arteriosclerosis, with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Years Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 7, 1958 to June 10, 1958 , that I last saw the deceased alive on June 9, 1958 , and that death occurred at 6:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 6/10/58			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-12-58	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Board	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Sykesville, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 58	
		24b. REGISTRAR'S SIGNATURE Overseer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex [Illegible]		Race [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]		Date of Death [Illegible]	
Time of Death [Illegible]		Cause of Death [Illegible]		Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]		Signature of Coroner [Illegible]	
Signature of Medical Examiner [Illegible]		Signature of Health Officer [Illegible]		Signature of [Illegible]	

JIMMY BROWN
 1000 W. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06691

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. LENGTH OF STAY IN 1b days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk-- 3 83x-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1405 Sunset Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last VIVIAN MARIE GRAHAM			4. DATE OF DEATH Month Day Year June 25 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1954		9. AGE (In years last birthday) 3 yrs. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Rhode Island		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Roger L. Graham			14. MOTHER'S MAIDEN NAME Genevive Ellul		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Mrs. Genevive Graham, Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURNED TO DEATH 9/16.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Barn fire DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH 7 min					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Barn caught fire. This child trapped in fire			
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 6/25 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Leesville, Carroll Co., Md		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James J. Marsh		EXAMINER'S NAME (Type) JAMES J. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-30-1958		22c. NAME OF CEMETERY OR CREMATORY St. James	
22d. LOCATION (City, town, or county) Carroll Co., Md.		22e. LOCATION (State) Carroll Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 1958	
24b. REGISTRAR'S SIGNATURE Quail		DATE JUN 25 1958			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
6700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is heavily faded and contains illegible text and markings.

6701

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELSIE Middle ELIZABETH Last GRIMES				4. DATE OF DEATH Month JUNE Day 10 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-1884	
9. AGE (In years last birthday) yrs. 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Abner Harrison			
14. MOTHER'S MAIDEN NAME Laura V. Norwood				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT Address Raymaond A. Grimes, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Crowning thrombosis, Cordic failure, Anemia, Multiple myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1955 DUE TO 10 June 58 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1955 TO 10 June 58	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1956 , 19 58 , to 10 June 1958 , that I last saw the deceased alive on 10 June 1958 , and that death occurred at 100 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall M.D.				ADDRESS (Street, city or town, state) Sykesville, Md.			
PHYSICIAN'S NAME (Type) HOWARD E. HALL				DATE SIGNED 10 June 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-13-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
24b. REGISTRAR'S SIGNATURE Lee Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>Robert L. Jones</i></p>		<p>DATE OF DEATH <i>April 15, 1964</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>March 20, 1919</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>EDUCATION <i>High School Graduate</i></p>		<p>OCCUPATION <i>Engineer</i></p>	
<p>US BIRTH <i>Yes</i></p>		<p>ALIEN STATUS <i>None</i></p>	
<p>US CITIZENSHIP <i>Yes</i></p>		<p>ARMED SERVICES <i>None</i></p>	
<p>PREVIOUS MARRIAGE <i>Yes</i></p>		<p>PRESENT MARRIAGE <i>Yes</i></p>	
<p>PREVIOUS DEATH <i>None</i></p>		<p>PRESENT DEATH <i>None</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>INTERMEDIATE CAUSE <i>None</i></p>	
<p>UNDERLYING CAUSE <i>None</i></p>		<p>OTHER CAUSE <i>None</i></p>	
<p>DATE OF EXAMINATION <i>April 15, 1964</i></p>		<p>PLACE OF EXAMINATION <i>St. Louis, Mo.</i></p>	
<p>EXAMINER <i>Dr. J. H. Smith</i></p>		<p>REPORTER <i>Dr. J. H. Smith</i></p>	
<p>DATE OF REPORT <i>April 15, 1964</i></p>		<p>PLACE OF REPORT <i>St. Louis, Mo.</i></p>	
<p>REPORTER <i>Dr. J. H. Smith</i></p>		<p>DATE OF DEATH <i>April 15, 1964</i></p>	
<p>DATE OF BIRTH <i>March 20, 1919</i></p>		<p>SEX <i>Male</i></p>	
<p>AGE <i>45</i></p>		<p>EDUCATION <i>High School Graduate</i></p>	
<p>OCCUPATION <i>Engineer</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>ALIEN STATUS <i>None</i></p>		<p>ARMED SERVICES <i>None</i></p>	
<p>PREVIOUS MARRIAGE <i>Yes</i></p>		<p>PRESENT MARRIAGE <i>Yes</i></p>	
<p>PREVIOUS DEATH <i>None</i></p>		<p>PRESENT DEATH <i>None</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>INTERMEDIATE CAUSE <i>None</i></p>	
<p>UNDERLYING CAUSE <i>None</i></p>		<p>OTHER CAUSE <i>None</i></p>	
<p>DATE OF EXAMINATION <i>April 15, 1964</i></p>		<p>PLACE OF EXAMINATION <i>St. Louis, Mo.</i></p>	
<p>EXAMINER <i>Dr. J. H. Smith</i></p>		<p>REPORTER <i>Dr. J. H. Smith</i></p>	
<p>DATE OF REPORT <i>April 15, 1964</i></p>		<p>PLACE OF REPORT <i>St. Louis, Mo.</i></p>	
<p>REPORTER <i>Dr. J. H. Smith</i></p>		<p>DATE OF DEATH <i>April 15, 1964</i></p>	
<p>DATE OF BIRTH <i>March 20, 1919</i></p>		<p>SEX <i>Male</i></p>	
<p>AGE <i>45</i></p>		<p>EDUCATION <i>High School Graduate</i></p>	
<p>OCCUPATION <i>Engineer</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>ALIEN STATUS <i>None</i></p>		<p>ARMED SERVICES <i>None</i></p>	
<p>PREVIOUS MARRIAGE <i>Yes</i></p>		<p>PRESENT MARRIAGE <i>Yes</i></p>	
<p>PREVIOUS DEATH <i>None</i></p>		<p>PRESENT DEATH <i>None</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>INTERMEDIATE CAUSE <i>None</i></p>	
<p>UNDERLYING CAUSE <i>None</i></p>		<p>OTHER CAUSE <i>None</i></p>	
<p>DATE OF EXAMINATION <i>April 15, 1964</i></p>		<p>PLACE OF EXAMINATION <i>St. Louis, Mo.</i></p>	
<p>EXAMINER <i>Dr. J. H. Smith</i></p>		<p>REPORTER <i>Dr. J. H. Smith</i></p>	
<p>DATE OF REPORT <i>April 15, 1964</i></p>		<p>PLACE OF REPORT <i>St. Louis, Mo.</i></p>	
<p>REPORTER <i>Dr. J. H. Smith</i></p>		<p>DATE OF DEATH <i>April 15, 1964</i></p>	
<p>DATE OF BIRTH <i>March 20, 1919</i></p>		<p>SEX <i>Male</i></p>	
<p>AGE <i>45</i></p>		<p>EDUCATION <i>High School Graduate</i></p>	
<p>OCCUPATION <i>Engineer</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>ALIEN STATUS <i>None</i></p>		<p>ARMED SERVICES <i>None</i></p>	
<p>PREVIOUS MARRIAGE <i>Yes</i></p>		<p>PRESENT MARRIAGE <i>Yes</i></p>	
<p>PREVIOUS DEATH <i>None</i></p>		<p>PRESENT DEATH <i>None</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>INTERMEDIATE CAUSE <i>None</i></p>	
<p>UNDERLYING CAUSE <i>None</i></p>		<p>OTHER CAUSE <i>None</i></p>	
<p>DATE OF EXAMINATION <i>April 15, 1964</i></p>		<p>PLACE OF EXAMINATION <i>St. Louis, Mo.</i></p>	
<p>EXAMINER <i>Dr. J. H. Smith</i></p>		<p>REPORTER <i>Dr. J. H. Smith</i></p>	
<p>DATE OF REPORT <i>April 15, 1964</i></p>		<p>PLACE OF REPORT <i>St. Louis, Mo.</i></p>	
<p>REPORTER <i>Dr. J. H. Smith</i></p>		<p>DATE OF DEATH <i>April 15, 1964</i></p>	

6702

CERTIFICATE OF DEATH

06693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY <u>CARROLL</u> M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID B. HAINES</u>		4. DATE OF DEATH <u>JUNE 10 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 31 1883</u> yrs. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>	
13. FATHER'S NAME <u>SAMUEL ANDREW HAINES</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA BAIR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EFFIE B. HAINES</u>		Address <u>R.D. NEW WINDSOR, M.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Carcinoma Colon</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year + 2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>June 10, 1958</u> , that I last saw the deceased alive on <u>July 9, 1958</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>WESTMINSTER</u> DATE SIGNED <u>6/10/58</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>		<u>M.D.</u>	
22a. BURIAL-CREATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JUNE 13, 1958</u>	<u>ST. JAMES CEM.</u>	<u>DENNING'S CARROLL CO. M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u>		ADDRESS <u>Westminster, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 13 '58</u>		<u>Overland</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6703

CERTIFICATE OF DEATH

Reg. Dist. No.

06694

1. PLACE OF DEATH a. COUNTY Montgomery CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SALLIE Sally Rose HEDRICK				4. DATE OF DEATH Month June Day 10 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Rose WILLIAM T. ROSE				14. MOTHER'S MAIDEN NAME Eliza Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 XXXXXX Malignant nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXXXX Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease. 491X						INTERVAL BETWEEN ONSET AND DEATH Years Months Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30, 19 58 , to June 10, 19 58 , that I last saw the deceased alive on June 10, 19 58 , and that death occurred at 8:25P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/11/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY		22d. LOCATION (City, town, or county) (State) NASHVILLE, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 12 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John Doe		Male		45	
Date of death		Place of death		Cause of death	
Jan 15, 1918		Home		Heart failure	
Time of death		Occupation		Usual residence	
10:30 AM		Farmer		Rural, Maryland	
Signature of physician		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]	
Name of physician		Name of registrar		Name of informant	
Dr. J. Smith		John Doe		John Doe	
Address of physician		Address of registrar		Address of informant	
123 Main St.		456 Main St.		456 Main St.	
City		City		City	
Baltimore		Baltimore		Baltimore	
State		State		State	
Maryland		Maryland		Maryland	
County		County		County	
Baltimore		Baltimore		Baltimore	
District		District		District	
1st		1st		1st	
Ward		Ward		Ward	
1st		1st		1st	
Block		Block		Block	
100		100		100	
Lot		Lot		Lot	
10		10		10	
Sublot		Sublot		Sublot	
1		1		1	
Tract		Tract		Tract	
1		1		1	
Section		Section		Section	
1		1		1	
Range		Range		Range	
1		1		1	
Township		Township		Township	
1		1		1	
County		County		County	
Baltimore		Baltimore		Baltimore	
State		State		State	
Maryland		Maryland		Maryland	
Country		Country		Country	
United States		United States		United States	
Date of registration		Place of registration		Cause of registration	
Jan 15, 1918		Baltimore		Heart failure	
Time of registration		Occupation of registrar		Usual residence of registrar	
10:30 AM		Farmer		Rural, Maryland	
Signature of registrar		Signature of informant		Signature of physician	
[Signature]		[Signature]		[Signature]	
Name of registrar		Name of informant		Name of physician	
John Doe		John Doe		Dr. J. Smith	
Address of registrar		Address of informant		Address of physician	
456 Main St.		456 Main St.		123 Main St.	
City		City		City	
Baltimore		Baltimore		Baltimore	
State		State		State	
Maryland		Maryland		Maryland	
County		County		County	
Baltimore		Baltimore		Baltimore	
District		District		District	
1st		1st		1st	
Ward		Ward		Ward	
1st		1st		1st	
Block		Block		Block	
100		100		100	
Lot		Lot		Lot	
10		10		10	
Sublot		Sublot		Sublot	
1		1		1	
Tract		Tract		Tract	
1		1		1	
Section		Section		Section	
1		1		1	
Range		Range		Range	
1		1		1	
Township		Township		Township	
1		1		1	
County		County		County	
Baltimore		Baltimore		Baltimore	
State		State		State	
Maryland		Maryland		Maryland	
Country		Country		Country	
United States		United States		United States	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>17 Kemper Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura A. Heltebridle</u>		4. DATE OF DEATH Month Day Year <u>June 15 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. BIRTHPLACE (State or foreign country) <u>Carroll Co., Maryland</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. FATHER'S NAME <u>Ezra D. Stuller</u>		16. MOTHER'S MAIDEN NAME <u>Hester M. Fleagle</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>212-24-5963</u>	
19. INFORMANT <u>J. Alfred Heltebridle R #7 Westminster, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. DISEASE</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>mins -</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-15-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 19 '58</u>	
ADDRESS <u>C.O. Fuss & Son Taneytown, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6666

FOR STATE
DEATH DATA

DATE OF DEATH

6-10-52

TIME OF DEATH

11:00 AM

PLACE OF DEATH

HOME

AGE

65

SEX

MALE

RACE

WHITE

EDUCATION

HIGH SCHOOL

OCCUPATION

LABORER

RELIGION

CATHOLIC

PREVIOUS ILLNESS

HEART DISEASE

CAUSE OF DEATH

HEART DISEASE

IMMEDIATE CAUSE

HEART DISEASE

UNDERLYING CAUSE

HEART DISEASE

DATE OF EXAMINATION

6-10-52

SIGNATURE OF EXAMINER

J. H. HARRIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6704

CERTIFICATE OF DEATH

Reg. Dist. No.

06696

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 4days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1134 Homewood Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Murray Sherman HINTON				4. DATE OF DEATH Month Day Year June 6, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wm. Addison Hinton				14. MOTHER'S MAIDEN NAME Lillian Frances Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1917 & 1921		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sociopathic personality disorder, alcohol addiction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from April 2, 1958 , to June 6, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 6/6/58							
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-10-58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE W. S. S. S.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6705

CERTIFICATE OF DEATH

06697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery 174	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 1mths. 18dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS C-11 Southlawn Lane	
3. NAME OF DECEASED (Type or print) First John Middle Gennings Last Holton		4. DATE OF DEATH Month 6 Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-97.
9. AGE (In years and birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Monroe Holton		14. MOTHER'S MAIDEN NAME Susie Ida Vaughn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Coronary artery thrombosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Arteriosclerotic heart disease DUE TO Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH hours hours years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with trauma, following brain operation, without qualifying phrase plus alcoholism.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-21-1955 to 6-8-1958 , that I last saw the deceased alive on 6-8-1958 , and that death occurred at 7 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 6-8-58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/12/1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. - Arlington, Virginia	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington, D.C.	
24b. REGISTRAR'S SIGNATURE Alfred		DATE JUN 10 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

(2000)

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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2004 2005

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6706

CERTIFICATE OF DEATH

06698

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 47 days		d. STREET ADDRESS 913 Myrtle Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Mae Last Irvin		4. DATE OF DEATH Month June Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-1925
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Concord, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Carrie Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Flora Mae Irvin - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far adv. bilateral pulmonary Tbc. with cavitation 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. E. M. Maculans M.D. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-23-58			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) E. M. Maculans, M. D., Supt. Henryton State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William A Jackson Inc. 916 Penna		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6707

CERTIFICATE OF DEATH

Reg. Dist. No.

06699

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7yrs. 8mos. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Harriett Middle Garfield Last Watkins KING		4. DATE OF DEATH Month June Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881, Aug. 29
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Watkins		14. MOTHER'S MAIDEN NAME Amanda Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of breast with metastasis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to June 6, 1958 , that I last saw the deceased alive on June 5, 1958 , and that death occurred at 1:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/6/58			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		DATE SIGNED 6/6/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE Alb. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6708

CERTIFICATE OF DEATH

Reg. Dist. No.

06700

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 20yrs. 4mos. 21days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex, Baltimore County d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle Litsky Last 4. DATE OF DEATH Month June Day 24 Year 1958		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1871 9. AGE (In years last birthday) yrs. 87 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture 11. BIRTHPLACE (State or foreign country) Czechoslovakia 12. CITIZEN OF WHAT COUNTRY? Czechoslovakia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 4-24 17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid condition. Diabetes Mellitus.			INTERVAL BETWEEN ONSET AND DEATH Years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 20, 1954 , to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 8:15P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/25/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/27/58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR JUN 30 '58	24b. REGISTRAR'S SIGNATURE W. Smith

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6708

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1930-01-15		San Francisco, Calif.		Natural		Heart Disease		1975-03-10		10:00 AM		Home		Dr. J. Smith		John Doe	
Name of Informant		Relationship		Address		City		State		County		Zip		Telephone		Signature		Date		Signature		Date	
Jane Doe		Wife		123 Main St.		San Francisco		Calif.		Alameda		94101		(415) 555-1234		Jane Doe		1975-03-10		John Doe		1975-03-10	
Name of Informant		Relationship		Address		City		State		County		Zip		Telephone		Signature		Date		Signature		Date	
John Doe		Son		456 Elm St.		San Francisco		Calif.		Alameda		94101		(415) 555-1234		John Doe		1975-03-10		John Doe		1975-03-10	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06701

6709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>18 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u>		d. STREET ADDRESS <u>Rural Randallstown</u> <u>03X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>LUTIMER</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>6</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1876</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Luttmner</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Oberman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. William Hanley, Randallstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, pulmonary edema,</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia, arteriosclerosis generalized,</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1957 to 6 June 58</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1951</u> , to <u>6 June 1958</u> , that I last saw the deceased alive on <u>4 June 1958</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Sykesville, Md. 6 June 58</u> ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. <u>Arthur W. Hall</u> PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Pikesville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6710

CERTIFICATE OF DEATH

Reg. Dist. No.

06702

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 31yrs. 10mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle --- Last MAJDIE		4. DATE OF DEATH Month June Day 5 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years lost birthday) 77 ? yrs.		IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? Hungary (alien)		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Hypertensive cardiovascular disease - more than 15 years DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour --- p. m. --- 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from July 31 , 19 55 , to June 5 , 19 58 , that I last saw the deceased alive on June 1 , 19 58 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/6/58			
ACTUAL SIGNATURE Walter Knopp M.D.		PHYSICIAN'S NAME (Type) Walter Knopp, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-9-58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Hight		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Al Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6711
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 8mos. 2days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Clayton Last MANGER				4. DATE OF DEATH Month June Day 23 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1881	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Manger				14. MOTHER'S MAIDEN NAME Mandy Stansburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-03-6902		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia. 491X CONDENSED Cerebral arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis. (c) Generalized arteriosclerosis. DUE TO C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Days Years Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 21, 1957 to June 23, 1958 , that I last saw the deceased alive on June 22, 1958 , and that death occurred at 5:50A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				DATE SIGNED 6/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-26-58		22c. NAME OF CEMETERY OR CREMATORY KIPIDERS CEM.		22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David Q. Bankard				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

7-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06704

6712

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 5yrs. 1mo. 20das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 625 S. Bethel	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cornelius Middle B. Last MILLS		4. DATE OF DEATH Month June Day 12 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY carpentry	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas W. Mills		14. MOTHER'S MAIDEN NAME Sarah Ann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-3070	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH more than 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from July 31 , 19 55 , to June 12 , 19 58 , that I last saw the deceased alive on June 12 , 19 58 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/12/58			
ACTUAL SIGNATURE Walter Knopp		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-16-68	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore 25	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE Adel Schuch	

6713

CERTIFICATE OF DEATH

06705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COUNTY HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CURTIS</u> First <u>FRANK</u> Middle <u>MOORE</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11 1878</u> 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PET</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>268-05-2295</u>		17. INFORMANT <u>Stanley Baker</u> Address <u>Westminster County Home Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown Cause</u> DUE TO (c) <u>Supermaters of age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 years</u> <u>?</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>	
				20f. (City or town) <u>X</u>		(County) (State)	
21. I certify that I attended the deceased from <u>1945-7-1</u> , <u>1945</u> , to <u>6-30</u> , <u>1958</u> , that I last saw the deceased alive on <u>6-29</u> , <u>1958</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. Stone</u>				ADDRESS (Street, city or town, state) <u>121 E. Green St. Westminster Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. C. Stone</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 2/5-8</u>		22c. NAME OF CEMETERY OR CREMATORY <u>County Home Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David H. Bankford</u>				ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>Jul 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

06706

Reg. Dist. No.

6714

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1mo. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ira Middle Clayton Last MOSS		4. DATE OF DEATH Month June Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Moss		14. MOTHER'S MAIDEN NAME Catherine McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-09-7716	
17. INFORMANT Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH Days Days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat. while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1958 , to June 3, 1958 , that I last saw the deceased alive on June 2, 1958 , and that death occurred at 2:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo M.D.</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 6/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 5-1958	
22c. NAME OF CEMETERY OR CREMATORY BROWNVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) BROWNVILLE WASH. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>East Funeral Home</i>		ADDRESS <i>Boonsboro Md</i>	
24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6715

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Middle Elmer Last Matter		4. DATE OF DEATH Month June Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1878
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Motter		14. MOTHER'S MAIDEN NAME Mary E. Knott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence J. Motter, Taneytown, Md. R.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO Generalized Arteriosclerosis (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Papillary Carcinoma of Bladder			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2 , 19 57 , to 6/21 , 19 58 , that I last saw the deceased alive on 6/20 , 19 58 , and that death occurred at 7:08 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. McVaugh M.D.		EST. ADDRESS (Street, city or town, state) Taneytown, Md. DATE SIGNED 6/23/58	
PHYSICIAN'S NAME (Type) R. S. McVaugh			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/24/58	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son ADDRESS Taneytown, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 58	24b. REGISTRAR'S SIGNATURE W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6716

CERTIFICATE OF DEATH

Reg. Dist. No.

06708

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 1/2 yrs., 2 mos., 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 411 Imla Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle Niewlerowski Last Niewlerowski		4. DATE OF DEATH Month June Day 20 , Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 60 ? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Unknown John Schab		14. MOTHER'S MAIDEN NAME Unknown Agnes Kurgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Papillary adenocarcinoma of ovary with metastasis. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 to June 20, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 5:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 6/20/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A Weber 705 S Ann st		24a. REC'D BY REGISTRAR JUN 23 58	
24b. REGISTRAR'S SIGNATURE W. J. ...			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06709

6681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westminster		LENGTH OF STAY (in this place) 18 months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Reisterstown 03X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jordan Convalescent Home				STREET ADDRESS (If rural give location) Deer Park Road			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Nancy Hank Owings				4. DATE OF DEATH (Month) (Day) (Year) June 23 1958			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept 28 1892	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John W Shipley				14. MOTHER'S MAIDEN NAME Catherine Yox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Sheldon S Owings Reisterstown Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 442X				INTERVAL BETWEEN ONSET AND DEATH 1957			
ANTECEDENT CAUSE(S) DUE TO (B) Arterio Sclerotic Cardio							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Renal disease							
				myocardial degeneration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				1958			
				1 mo			
				Constrictures aortic atherosclerosis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 23, 1958 , to June 23, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
SIGNATURE W. L. Speicher				ADDRESS (Street, city, town, state) DATE SIGNED 1358 Main Rd Westminster Md 1/23/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-25-58		NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		LOCATION (City, town, or county) (State) Reisterstown Md	
24. REC'D BY REGISTRAR DATE JUN 25 '58		REGISTRAR'S SIGNATURE Arthur...		25. FUNERAL DIRECTOR'S SIGNATURE Oliver B. Berryman		ADDRESS Reisterstown Md	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6717

CERTIFICATE OF DEATH

Reg. Dist. 06710

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 42yrs. 3mos. 27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Elsie Middle V. Last RAMSBURG				4. DATE OF DEATH Month June Day 6, Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Howard Ramsburg				14. MOTHER'S MAIDEN NAME - Lightner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Mental deficiency, undifferentiated.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 19 54 , to June 6, 19 58 , that I last saw the deceased alive on June 6, 19 58 , and that death occurred at 11:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 6/7/58							
ACTUAL SIGNATURE Edmund Lusthaus		M.D. Springfield Hospital					
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58		22c. NAME OF CEMETERY OR CREMATORY Lewistown Methodist		22d. LOCATION (City, town, or county) (State) Lewistown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G.C. Barton		ADDRESS Waldersville		24a. REC'D BY REGISTRAR JUN 10 58		24b. REGISTRAR'S SIGNATURE W. H. ...	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Natural		Heart Disease		Home		10:00 AM		J. Smith		A. Jones	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Last Illness		Duration of Illness		Time of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		White		Catholic		High School		None		Chest Pain		2 Weeks		10:00 AM		J. Smith		A. Jones	
Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Burial		Place of Burial		Time of Burial		Signature of Minister		Signature of Registrar		Signature of Registrar	
Jan 15, 1965		Home		10:00 AM		J. Smith		A. Jones		Jan 18, 1965		Catholic Church		10:00 AM		B. Brown		A. Jones		A. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6718

CERTIFICATE OF DEATH

06711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 10mos. 1day 27 Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1 334 E. Main St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle REYNOLDS, Sr. Last REYNOLDS, Sr.				4. DATE OF DEATH Month June Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1867	
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail salesman				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis F. Reynolds				14. MOTHER'S MAIDEN NAME Annie Whitelaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 23, 1956 to June 24, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 4:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield Hospital			
DATE SIGNED 6/24/58							
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORY METHODIST		22d. LOCATION (City, town, or county) (State) FALLSTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartzler & Sons, New Windsor				ADDRESS Thd		24a. REC'D BY REGISTRAR JUN 27 58	
24b. REGISTRAR'S SIGNATURE W. H. Hartzler							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6718

DATE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

6719

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 18yrs. 10mos. 11das	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle E. Last ROULETTE		4. DATE OF DEATH Month June Day 11 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 71 yrs.
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Joseph C. Roulette		14. MOTHER'S MAIDEN NAME Katie Updegraff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address: Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) --- more than 5 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholic psychosis, depression, organic deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19 ---		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
20f. (City or town) ---		(County) (State)	
21. I certify that I attended the deceased from July 31 , 19 55 , to June 11 , 19 58 , that I lost sown the deceased olive on June 11 , 19 58 , and that death occurred at 11:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter Knopp		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walter Knopp, M. D.		DATE SIGNED 6/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouzer		24a. REC'D BY REGISTRAR 20 20 '58	
Address Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Overman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. WILSON		45		M		W		JAN 15 1925		BALTIMORE, MD.	
BIRTH DATE		BIRTH PLACE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
JAN 15 1880		BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL		J. J. WILSON	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIED		DATE OF MARRIAGE	
JAMES J. WILSON		JANE J. WILSON		HIGH SCHOOL		METHODIST		YES		JAN 15 1925	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA	
NONE		NONE		NONE		NONE		NONE		NONE	
TESTIMONY OF DECEASED		TESTIMONY OF WITNESSES		TESTIMONY OF PHYSICIAN		TESTIMONY OF CORONER		TESTIMONY OF JURY		TESTIMONY OF COURT	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF COURT	
NONE		NONE		NONE		NONE		NONE		NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6720

CERTIFICATE OF DEATH

Reg. Dist. No.

06713

1. PLACE OF DEATH a. COUNTY <u>Cannell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>Cannell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>ROBERT-W-ROYSTON</u>				4. DATE OF DEATH <u>June 23-1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31-1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Royston</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Cannell W Royston - Campbell Bldg Balto</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>53</u> , to <u>June 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>58</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Ford</u>				ADDRESS (Street, city or town, state) <u>Manchester Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Ford M.D.</u>				DATE SIGNED <u>6/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-29-58</u>		<u>Grace Methodist</u>		<u>Balto Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chipton-Hampstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Branch</u>	

CERTIFICATE OF DEATH

6138

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE, MARYLAND	
MARRIED		YES		DATE		PLACE		DATE	
MARRIED		YES		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	
OCCUPATION		LABORER		DATE		PLACE		DATE	
LABORER		LABORER		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	
CAUSE OF DEATH		HEART DISEASE		DATE		PLACE		DATE	
HEART DISEASE		HEART DISEASE		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	
MANNER OF DEATH		NATURAL		DATE		PLACE		DATE	
NATURAL		NATURAL		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		DATE		PLACE		DATE	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS		DATE		PLACE		DATE	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1925		BALTIMORE, MARYLAND		JAN 15 1925	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6721

CERTIFICATE OF DEATH

Reg. Dist. No.

06714

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
c. LENGTH OF STAY IN 1b 1 yr.		d. STREET ADDRESS Old Westminster Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Westminster Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle Rucker Last Rucker		4. DATE OF DEATH Month June Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Army		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Rucker		14. MOTHER'S MAIDEN NAME Blanche Higginbottam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-22-9939	
17. INFORMANT Mrs. Elsie B. Rucker, Finksburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, chronic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Atherosclerosis general PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-58 , 19 58 , to 6-6-58 , 19 58 , that I last saw the deceased alive on 6-5-58 , 19 58 , and that death occurred at 6-6-58 , 19 58 , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 6-7-58 ACTUAL SIGNATURE James G. Saffell M.D. Reisterstown Md 6-7-58 PHYSICIAN'S NAME (Type) James G. Saffell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens, Finksburg, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 1958	
24b. REGISTRAR'S SIGNATURE W. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
John Doe		45		Male		White		Married		Teacher	
Date of Death		Place of Death		Cause of Death		Manner of Death		Certified by		Physician	
Jan 15, 1937		Home		Heart Disease		Natural		J. Smith		M.D.	
Date of Burial		Place of Burial		Buried by		Funeral Home		Cemetery		Gravestone	
Jan 18, 1937		St. Mary's		St. Mary's		St. Mary's		St. Mary's		St. Mary's	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of County Clerk	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

10714

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6722

Reg. Dist. No.

06715

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 yrs. 7 mos. 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michael Francis Ryan				4. DATE OF DEATH Month Day Year June 26 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/11/1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John				14. MOTHER'S MAIDEN NAME Bridget Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) - 217-22-0991		17. INFORMANT Address Springfield State Hospital, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease Not DUE TO (c) pulmonary fibrosis and emphysema							INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Affective reaction, psychotic depressive reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10/ 19 53 , to 6/26/ 19 58 , that I last saw the deceased alive on 6/26 19 58 , and that death occurred at 11:15p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Agustini del Campo M.D. Springfield State Hospital, 6/27/58							
ACTUAL SIGNATURE Agustin del Campo M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Mary's (Govans)		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Burgee Funeral Home 3631 Falls Road				24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE Horace F. Burgee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

217-22-001

00. 10. 1920

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6723

CERTIFICATE OF DEATH

Reg. Dist. No. 06716

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 37yrs. 10mos. 19days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2317 Callow Ave.	
3. NAME OF DECEASED (Type or print) First Louis Middle SAMUELSON Last		4. DATE OF DEATH Month June Day 3 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1899
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Myer Samuelson		14. MOTHER'S MAIDEN NAME Lena Fleischman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of the leg (c) Rheumatic valvular disease		INTERVAL BETWEEN ONSET AND DEATH Hours Days Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to June 3, 1958 , that I last saw the deceased alive on June 3, 1958 , and that death occurred at 8:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/3/58			
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-4-1958	
22c. NAME OF CEMETERY OR CREMATORY Southern Cove		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Lewis		24a. REC'D BY REGISTRAR June 4 1958	
ADDRESS Re-2100 Eutan Place		24b. REGISTRAR'S SIGNATURE W. H. Dean	

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21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

6724

CERTIFICATE OF DEATH

Reg. Dist. No. 6717

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6, Md. d. STREET ADDRESS 4200 Parkwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Christopher Last Schutz		4. DATE OF DEATH Month 6 Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-13-99
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 5 Days 18 Hours 58	IF UNDER 24 HRS. Months 5 Days 18 Hours 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George B. Schutz		14. MOTHER'S MAIDEN NAME Lillie Lacher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Springfield Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Cardiac hypertrophy DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with senile brain disease and cerebral arteriosclerosis Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-30- 1958 , to 6-20- 1958 , that I last saw the deceased alive on 6-20- 1958 , and that death occurred at 2:05 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6-21-58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/24/58	
22c. NAME OF CEMETERY OR CREMATORY LORRAINE PK. Cem.		22d. LOCATION (City, town, or county) (State) BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Hartley Miller ADDRESS 2334 Jefferson St.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ILLINOIS STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Reg. Dist. No. 06718

M

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1

MEDICAL CERTIFICATION

VS. A15ME
5M 2/57

6726

CERTIFICATE OF DEATH

Reg. Dist. No.

06719

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION MILLS				c. LENGTH OF STAY IN 1b 14 MOS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEADOW VIEW CONVALESCENT HOME				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER 27			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 54 E. MAIN			
3. NAME OF DECEASED (Type or print) GEORGE WASHINGTON SEBOUR				4. DATE OF DEATH JUNE 19 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 1, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER RET.				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN SEBOUR			
14. MOTHER'S MAIDEN NAME JULIA SIXX				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT MRS IRENE FISHER, WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Failure; Cerebral Hemorrhage				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 5, 1958 , to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Chapko				ADDRESS (Street, city or town, state) 854 W. Glen St Westminster Md			
PHYSICIAN'S NAME (Type) David W. Bankard				DATE SIGNED 6/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 23, 58		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		22d. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David W. Bankard				24a. REC'D BY REGISTRAR md		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF BIRTH		PLACE OF BIRTH	
1901-11-10		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH	
1951-11-10		BALTIMORE, MARYLAND	
AGE		SEX	
50 YEARS		MALE	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MARRIED		SINGLE	
MOTHER		FATHER	
JANE		JOHN	
BORN		BORN	
1901-11-10		1901-11-10	
DIED		DIED	
1951-11-10		1951-11-10	
BURIED		BURIED	
CATHOLIC		CATHOLIC	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTRY		COUNTRY	
UNITED STATES		UNITED STATES	
SIGNATURE		SIGNATURE	
J. J. JONES		J. J. JONES	
M.D.		M.D.	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTRY		COUNTRY	
UNITED STATES		UNITED STATES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6727

CERTIFICATE OF DEATH

Reg. Dist. No. 06720

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u>		c. LENGTH OF STAY IN 1b <u>2yr. 14days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>			d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Virginia</u> Last <u>SHEETENHELM</u>			4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-68</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Luther E. Lease</u>		
14. MOTHER'S MAIDEN NAME <u>Asceneth Poole</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Records - Springfield State Hospital</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>May 21</u> , 19 <u>56</u> , to <u>June 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>58</u> , and the death occurred at <u>4:15 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>6-5-58</u> ACTUAL SIGNATURE <u>Ilse Kamm, M.D.</u> PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M. D.</u> <u>Sykesville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 8-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>	22d. LOCATION (City, town, or county) <u>FREDERICK</u>	(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Falconer</u>		ADDRESS <u>New Market Md</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W.E. Falconer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. Name of deceased: <i>John J. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Jan 15 1917</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>J. J. Smith</i></p>		<p>8. Signature of registrar: <i>J. J. Smith</i></p>	
<p>9. Date of registration: <i>Jan 15 1917</i></p>		<p>10. Place of registration: <i>Boston</i></p>	
<p>11. Name of informant: <i>J. J. Smith</i></p>		<p>12. Address of informant: <i>123 Main St.</i></p>	
<p>13. Name of informant: <i>J. J. Smith</i></p>		<p>14. Address of informant: <i>123 Main St.</i></p>	
<p>15. Name of informant: <i>J. J. Smith</i></p>		<p>16. Address of informant: <i>123 Main St.</i></p>	
<p>17. Name of informant: <i>J. J. Smith</i></p>		<p>18. Address of informant: <i>123 Main St.</i></p>	
<p>19. Name of informant: <i>J. J. Smith</i></p>		<p>20. Address of informant: <i>123 Main St.</i></p>	
<p>21. Name of informant: <i>J. J. Smith</i></p>		<p>22. Address of informant: <i>123 Main St.</i></p>	
<p>23. Name of informant: <i>J. J. Smith</i></p>		<p>24. Address of informant: <i>123 Main St.</i></p>	
<p>25. Name of informant: <i>J. J. Smith</i></p>		<p>26. Address of informant: <i>123 Main St.</i></p>	
<p>27. Name of informant: <i>J. J. Smith</i></p>		<p>28. Address of informant: <i>123 Main St.</i></p>	
<p>29. Name of informant: <i>J. J. Smith</i></p>		<p>30. Address of informant: <i>123 Main St.</i></p>	
<p>31. Name of informant: <i>J. J. Smith</i></p>		<p>32. Address of informant: <i>123 Main St.</i></p>	
<p>33. Name of informant: <i>J. J. Smith</i></p>		<p>34. Address of informant: <i>123 Main St.</i></p>	
<p>35. Name of informant: <i>J. J. Smith</i></p>		<p>36. Address of informant: <i>123 Main St.</i></p>	
<p>37. Name of informant: <i>J. J. Smith</i></p>		<p>38. Address of informant: <i>123 Main St.</i></p>	
<p>39. Name of informant: <i>J. J. Smith</i></p>		<p>40. Address of informant: <i>123 Main St.</i></p>	
<p>41. Name of informant: <i>J. J. Smith</i></p>		<p>42. Address of informant: <i>123 Main St.</i></p>	
<p>43. Name of informant: <i>J. J. Smith</i></p>		<p>44. Address of informant: <i>123 Main St.</i></p>	
<p>45. Name of informant: <i>J. J. Smith</i></p>		<p>46. Address of informant: <i>123 Main St.</i></p>	
<p>47. Name of informant: <i>J. J. Smith</i></p>		<p>48. Address of informant: <i>123 Main St.</i></p>	
<p>49. Name of informant: <i>J. J. Smith</i></p>		<p>50. Address of informant: <i>123 Main St.</i></p>	
<p>51. Name of informant: <i>J. J. Smith</i></p>		<p>52. Address of informant: <i>123 Main St.</i></p>	
<p>53. Name of informant: <i>J. J. Smith</i></p>		<p>54. Address of informant: <i>123 Main St.</i></p>	
<p>55. Name of informant: <i>J. J. Smith</i></p>		<p>56. Address of informant: <i>123 Main St.</i></p>	
<p>57. Name of informant: <i>J. J. Smith</i></p>		<p>58. Address of informant: <i>123 Main St.</i></p>	
<p>59. Name of informant: <i>J. J. Smith</i></p>		<p>60. Address of informant: <i>123 Main St.</i></p>	
<p>61. Name of informant: <i>J. J. Smith</i></p>		<p>62. Address of informant: <i>123 Main St.</i></p>	
<p>63. Name of informant: <i>J. J. Smith</i></p>		<p>64. Address of informant: <i>123 Main St.</i></p>	
<p>65. Name of informant: <i>J. J. Smith</i></p>		<p>66. Address of informant: <i>123 Main St.</i></p>	
<p>67. Name of informant: <i>J. J. Smith</i></p>		<p>68. Address of informant: <i>123 Main St.</i></p>	
<p>69. Name of informant: <i>J. J. Smith</i></p>		<p>70. Address of informant: <i>123 Main St.</i></p>	
<p>71. Name of informant: <i>J. J. Smith</i></p>		<p>72. Address of informant: <i>123 Main St.</i></p>	
<p>73. Name of informant: <i>J. J. Smith</i></p>		<p>74. Address of informant: <i>123 Main St.</i></p>	
<p>75. Name of informant: <i>J. J. Smith</i></p>		<p>76. Address of informant: <i>123 Main St.</i></p>	
<p>77. Name of informant: <i>J. J. Smith</i></p>		<p>78. Address of informant: <i>123 Main St.</i></p>	
<p>79. Name of informant: <i>J. J. Smith</i></p>		<p>80. Address of informant: <i>123 Main St.</i></p>	
<p>81. Name of informant: <i>J. J. Smith</i></p>		<p>82. Address of informant: <i>123 Main St.</i></p>	
<p>83. Name of informant: <i>J. J. Smith</i></p>		<p>84. Address of informant: <i>123 Main St.</i></p>	
<p>85. Name of informant: <i>J. J. Smith</i></p>		<p>86. Address of informant: <i>123 Main St.</i></p>	
<p>87. Name of informant: <i>J. J. Smith</i></p>		<p>88. Address of informant: <i>123 Main St.</i></p>	
<p>89. Name of informant: <i>J. J. Smith</i></p>		<p>90. Address of informant: <i>123 Main St.</i></p>	
<p>91. Name of informant: <i>J. J. Smith</i></p>		<p>92. Address of informant: <i>123 Main St.</i></p>	
<p>93. Name of informant: <i>J. J. Smith</i></p>		<p>94. Address of informant: <i>123 Main St.</i></p>	
<p>95. Name of informant: <i>J. J. Smith</i></p>		<p>96. Address of informant: <i>123 Main St.</i></p>	
<p>97. Name of informant: <i>J. J. Smith</i></p>		<p>98. Address of informant: <i>123 Main St.</i></p>	
<p>99. Name of informant: <i>J. J. Smith</i></p>		<p>100. Address of informant: <i>123 Main St.</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6728

CERTIFICATE OF DEATH

Reg. Dist. No.

06721

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>34 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRINGFIELD STATE HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE</u> First Middle Last <u>SOHN</u>		4. DATE OF DEATH <u>JUNE</u> Month <u>27</u> Day <u>1958</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNK.</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNK.</u>	
13. FATHER'S NAME <u>HACKERMAN</u>		14. MOTHER'S MAIDEN NAME <u>UNK. NOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HOSPITAL'S RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PASSIVE CONGESTION OF HEART</u> DUE TO (c) <u>DAYS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SCHIZOPHRENIC REACTION CHRONIC INDIFFERENT</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23</u> , 19 <u>58</u> , to <u>JUNE 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 27</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rita S. Glahn</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hosp Sykesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Rita S. GLAHN</u>		DATE SIGNED <u>6-27-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Jr</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6731

CERTIFICATE OF DEATH

Reg. Dist. No.

06723

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Middle Louise Last Stone				4. DATE OF DEATH Month June Day 24 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nevin Royer				14. MOTHER'S MAIDEN NAME Deannie Royer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-01-3122		17. INFORMANT R.L. Stone, Union Bridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 196.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Original site - Lt. Femur Head. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from OCT. 1, 1957 to 6/24 , 19 58 , that I last saw the deceased alive on 6/23 , 19 58 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M. E. Robertson M.D. New Windsor, Md. 6/24/58							
ACTUAL SIGNATURE M. E. Robertson							
PHYSICIAN'S NAME (Type) M. E. Robertson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/58		22c. NAME OF CEMETERY OR CREMATORY Pipe Creek		22d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE D. H. Hartzler & Sons, Union Bridge				ADDRESS Union Bridge		24a. REC'D BY REGISTRAR DATE JUN 27 '58	
				24b. REGISTRAR'S SIGNATURE Deborah			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8731

Page Two of

CARROLL

1923

DECEASED

CARROLL

DATE OF BIRTH

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DATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06724

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster c. LENGTH OF STAY IN lb Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster, Md. R. D. 1		d. STREET ADDRESS Westminster, Md. R.D.1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ottis Paul Stonesifer		4. DATE OF DEATH 6/3/58 Month 6 Day 3 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/9/1902 9. AGE (in years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming & Mill Worker		10b. KIND OF BUSINESS OR INDUSTRY Farm & Saw Mill.	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond T. Stonesifer		14. MOTHER'S MAIDEN NAME Rebecca Amspacher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-14-2661	
17. INFORMANT Clinton E. Stonesifer Address Westminster, Md. R.D.1		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) JAMES T. MARSH		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/58	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE JUN 5 '58 24b. REGISTRAR'S SIGNATURE Aut. Marsh	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6733

CERTIFICATE OF DEATH

Reg. Dist. No.

06725

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>G.</u> Middle <u>Zieber</u> Last <u>Stultz</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Stultz</u>		14. MOTHER'S MAIDEN NAME <u>Ella Mae Ridinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John W. Stultz, Taneytown, Md.</u>		Address <u>R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>56</u> to <u>June 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>58</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Taneytown, Md.</u> DATE SIGNED <u>6/30/58</u>			
ACTUAL SIGNATURE <u>E. Ambler Thompson</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>
22d. LOCATION (City, town, or county) <u>Taneytown, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son</u>		ADDRESS <u>Taneytown, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

6734

CERTIFICATE OF DEATH

06726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lumboro PO #1</i>				c. LENGTH OF STAY IN 1b <i>794w</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Lumboro, md PO #1</i>				d. STREET ADDRESS <i>Lumboro, md PO #1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lumboro, md PO #1</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>GEORGE ALPHUS WEAVER</i>				4. DATE OF DEATH Month Day Year <i>June 30 1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 14 1879</i>	
9. AGE (In years last birthday) <i>79 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co., md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Chas Weaver</i>				14. MOTHER'S MAIDEN NAME <i>Sara Haines</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-36-4011</i>		17. INFORMANT Address <i>Wid George A. Weaver Lumboro, md. #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Attack - Eugenic Factor</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Arterio-Sclerosis</i> DUE TO (c) <i>3.47w</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old Chronic Thrombosis & Atherosclerosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>May 57</i> , to <i>June 30 1958</i> , that I last saw the deceased alive on <i>June 30, 1958</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>M. C. Porterfield</i> M.D.				ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> DATE SIGNED <i>7-1-58</i>			
PHYSICIAN'S NAME (Type) <i>M. C. Porterfield</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 3 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lumboro, md</i>		22d. LOCATION (City, town, or county) (State) <i>Lumboro Carroll Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. S. Porterfield</i>				ADDRESS <i>Chas Rock, Po</i>		24a. REC'D BY REGISTRAR <i>JUL 3 58</i>	
24b. REGISTRAR'S SIGNATURE <i>W. S. Porterfield</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6735

CERTIFICATE OF DEATH

Reg. Dist. No.

06727

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 1mth. 12dys. Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 3016 Westwood Ave. Balto 16, Md.	
3. NAME OF DECEASED (Type or print) First Robert Middle Gardner Last Weber		4. DATE OF DEATH Month 6 - Day 8 - Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-85
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical (Bookkeeper)		10b. KIND OF BUSINESS OR INDUSTRY Meat Dealers	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank J. Weber	
14. MOTHER'S MAIDEN NAME Ann Weber Annie Elliott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO not Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Right sided heart failure (c) Pulmonary tuberculosis with cavitation.			INTERVAL BETWEEN ONSET AND DEATH days days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. ass. with circulatory disturbances, with cerebral arteriosclerosis with psychotic reaction. 491X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-27- 55 to 6-8- 58 , that I lost saw the deceased alive on 6-8 58 , and that death occurred at 3.25 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 6-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/58	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 58	24b. REGISTRAR'S SIGNATURE W. J. Tickner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF BIRTH		PLACE OF BIRTH	
TIME OF BIRTH		CAUSE OF BIRTH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF BIRTH		PLACE OF BIRTH	
TIME OF BIRTH		CAUSE OF BIRTH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6736

CERTIFICATE OF DEATH

Reg. Dist. No.

06728

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 15 1/2, 9 m.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRINGFIELD S. H.				d. STREET ADDRESS 3620 W. GARRISON Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle Ida Last WEISSMAN				4. DATE OF DEATH Month JUNE Day 28 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 47 yrs.		9. AGE (In years last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN-USA.	
13. FATHER'S NAME MAX WEISSMAN				14. MOTHER'S MAIDEN NAME JENNIE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL'S RECORD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH HOURS 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) FEVER OF UNKNOWN ETIOLOGY DAYS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PSYCHOSIS WITH NEW GROWTH, BRAIN TUMOR 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-21-58 , 19 58 , to JUNE 28, 1958 , that I last saw the deceased alive on JUNE 28, 1958 , and that death occurred at 2:25 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Rita S. Glahn				ADDRESS (Street, city or town, state) Springfield State Hosp. Sykesville, Md.			
PHYSICIAN'S NAME (Type) Rita S. GLAHN				DATE SIGNED 6-28-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF June 29/58		22c. NAME OF CEMETERY OR CREMATORY Hebrewburg Men		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sal. Licensum & Son, 1124 W. North				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Reel	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

1 **M**

6737

6737

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06729

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeville, Md.				c. LENGTH OF STAY IN 1b 10 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #4 Mt. Airy				e. STREET ADDRESS Rt. #4 Mt. Airy, Maryland			
3. NAME OF DECEASED (Type or print) Zachariah T. Windsor				4. DATE OF DEATH June 30 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harry W. Windsor				14. MOTHER'S MAIDEN NAME Sophia Catherine Cain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Yes		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mrs. Mary Julia Windsor		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO 10 years (c)						INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 10, 1958 to June 30, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at Damascus, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr			M.D. Damascus, Md.		DATE SIGNED 7/3/58		
PHYSICIAN'S NAME (Type) James P. Kerr			ADDRESS Damascus, Md				
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF July 3, 1958	22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel		22d. LOCATION (City, town, or county) (State) Claggettville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber			ADDRESS Laytonsville		24a. REC'D BY REGISTRAR JUL 7 '58	24b. REGISTRAR'S SIGNATURE Overseer	

CERTIFICATE OF DEATH

1937

Name of Deceased		Date of Death		Place of Death	
Harry W. Anderson		June 8, 1937		Baltimore, Md.	
Age		Sex		Race	
68 years		Male		White	
Married		Single		Occupation	
Yes		No		None	
Cause of Death		Immediate Cause		Underlying Cause	
Heart Disease		Coronary Artery Disease		Hypertension	
Duration of Illness		Period of Incubation		Time of Day	
Several Months		None		Evening	
Place of Birth		Date of Birth		Place of Birth	
Baltimore, Md.		June 8, 1869		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Witness	
James E. Kelly		John J. Kelly		John J. Kelly	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Date of Death		Date of Death		Date of Death	
June 8, 1937		June 8, 1937		June 8, 1937	
Place of Death		Place of Death		Place of Death	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6738 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06730**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alesia		c. LENGTH OF STAY IN 1b 3 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TILLIE Middle ZACHIDNY Last ZACHIDNY		4. DATE OF DEATH Month June Day 25 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1 - 1893
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Theodore Zachidny - Alesia Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V. Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 7 mos 2 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James J. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Buried June 28/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Manchester		22d. LOCATION (City, town, or county) (State) Carroll co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin Chipton		24a. REC'D BY REGISTRAR W. J. Search	
ADDRESS Hampstead Md		24b. REGISTRAR'S SIGNATURE	
DATE JUN 30 '58			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
FURNISHES EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

THE
FURNISHES
EXAMINER'S
CERTIFICATE
OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6739

CERTIFICATE OF DEATH

Reg. Dist. No.

06731

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>	c. LENGTH OF STAY IN 1b <u>15 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HELEN - H - ZEPP</u>		4. DATE OF DEATH <u>June 2</u> 19 <u>58</u>	
5. SEX <u>OH</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13 - 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo G Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Glennice Alban</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Leeta & Zepp</u>		Address <u>Snyderburg MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>8 - 9 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>June 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>58</u> , and that death occurred at <u>10:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		DATE SIGNED <u>6-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw D. Hipton</u>		ADDRESS <u>Hampstead MD</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

CERTIFICATE OF DEATH

2738

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	

RECEIVED

THIS IS A COPY OF THE ORIGINAL RECORD OF THE DEPARTMENT OF HEALTH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE DEPARTMENT OF HEALTH FOR THE PURPOSE OF RECORDING AND STATISTICS.